ALLEGIANCE
FLEX ADVANTAGE™

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LIMITED-PURPOSE FSA
OPEN ENROLLMENT FORM

For Allegiance internal use only:

Group Number: _____ Plan Year: _____

Date Completed: _____ Entered By (initials): _____

Please print CLEARLY and complete ALL fields.

EMPLOYER: **CITY OF HELENA**	PLAN YEAR (mm/dd/yy – mm/dd/yy): -
DIVISION:	SSN:

NAME:	BIRTH DATE (mm/dd/yyyy):	☐ M ☐ F	☐ Married ☐ Single
MAILING ADDRESS:		PHONE:	
CITY: ST: ZIP:		EMAIL:	

LIMITED-PURPOSE HEALTH FLEXIBLE SPENDING ACCOUNT (FSA) ELECTION

PER PAY PERIOD DEDUCTION	NUMBER OF PAY PERIODS	TOTAL ANNUAL AMOUNT ELECTED
$_____	X 24 =	$_____

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (FSA) ELECTION

PER PAYPERIOD DEDUCTION	NUMBER OF PAY PERIODS	TOTAL ANNUAL AMOUNT ELECTED
$_____	X 24 =	$_____

DEDUCT INSURANCE PREMIUMS PRE-TAX ☐ **YES** ☐ **NO**

CERTIFICATION *I certify that these are my benefit elections and that:*

1. **I understand that only vision, dental, and some preventive expenses can be reimbursed under the limited-purpose health FSA.**
2. I authorize the "Before-Tax" deduction of a portion of my pay based on the elections above.
3. My health FSA election is for dental and vision expenses for myself, my spouse, and my qualified dependents.
4. My dependent care FSA election is for the care of my tax dependent children, under age 13, handicapped tax dependent, or elder tax dependent residing with me at least 8 hours each day.
5. I am aware that my unused contributions made under this plan cannot be refunded to me and become the property of my employer.
6. Reimbursement requests, sent to Allegiance, must be accompanied by documentation of the expense.
7. I understand that coverage applies only to expenses incurred within the plan year and during my period of employment.
8. I understand that this agreement cannot be changed or revoked during the plan year unless I experience a qualified change in status.

Both an employee signature and company authorization is required for enrollment to be completed.

Signed: _____ Date: _____

Company Authorization: _____ Date: _____

OTHER IRS CODE SECTION 125 DEDUCTIONS REQUESTED

INSURANCE PLAN	PREMIUM AMOUNT		PAY PERIODS		TOTAL ANNUAL AMOUNT
GROUP HEALTH	_____	x	_____	=	_____
DENTAL	_____	x	_____	=	_____
VISION	_____	x	_____	=	_____
_____	_____	x	_____	=	_____
_____	_____	x	_____	=	_____
			TOTAL	=	_____

HEALTH FSA EXPENSE ESTIMATION WORKSHEET - OPTIONAL

COMMON MEDICAL EXPENSES	AMOUNT	NOTES
Dental:	_____	_____
Vision:	_____	_____

TOTAL ANNUAL EXPENSES: _____ divide Total Annual Expenses by the number of pay periods to get the per pay period deduction amount.

- List all eligible out-of-pocket dental and vision expenses for you, your spouse, and your dependents.
- The full annual amount elected is available for eligible dental and vision expenses incurred at any time during the plan year.

DEPENDENT CARE FSA

- A dependent receiving care must be a child under the age of 13, or a tax dependent unable to provide for their own care, who resides with you.
- The care must be necessary for you and your spouse (if married), to go to work or for your spouse's education.
- Care may be provided by anyone other than your spouse or your children under the age of 19.
- Expenses for schooling, kindergarten and above, overnight camp and nursing homes are not reimbursable.
- The maximum you can elect, in a calendar year, is equal to the smallest of the following:
  - $5,000 – Married and filing federal taxes jointly or a single parent
  - $2,500 – Married and filing a separate federal tax return
  - you or your spouse's earned income

  An employee with a disabled spouse or a spouse who is a full-time student can elect up to $250/month for one child and $500/month for two or more children.
- The amount contributed, up to the amount of your annual election, is available for reimbursement.
- Do not include medical expense amounts in the day care account box.

- All elected "Before-Tax" amounts are exempt from Federal, State, FICA, and Medicare taxes.
- "Before-Tax" elections may reduce future Social Security benefits.
- Be conservative in the amount of your election. Any amount that is not used during the plan year will revert back to your employer. If you have a large expense coming up that you are not sure is reimbursable, call or email Allegiance:
  1-877-424-3570
  Flex-inquire@askallegiance.com